Town and County of Nantucket

REPORT OF PHYSICAL CONDITION

INSTRUCTIONS TO APPLICANT: Complete this form prior to your physical examination and give it to the examining physician at the time of examination. Answer all questions completely and accurately.

Name: (Last, First, Middle)		**Residential Address:**
Date of Birth: / /	**Social Security Number:**	

Health Questionnaire

Section A: Have you ever or do you now have any of the following? For "YES" answers, supply full details on the reverse side. If the condition required hospitalization, check the corresponding box, "HOSP."

CONDITION	NO	YES	HOSP	CONDITION	NO	YES	HOSP
1. HEAD INJURY				24. SENSITIVITY TO DUST			
2. BACK TROUBLE OR BACK PAIN				25. OTHER ALLERGIES			
3. ANY DEFECTS OF BONES OR JOINTS INCLUDING AMPUTATIONS, DISLOCATIONS, BROKEN BONES				26. FREQUENT COLDS			
4. LAMENESS				27. CANCER OF MALIGNANCY			
5. RHEUMATISM OR ARTHRITIS				28. TUMOR, GROWTH OR CYST			
6. TRICK OR LOCKED KNEE/ KNEE INJURY				29. ANY COMPLICATIONS FROM CHILDHOOD DISEASES			
7. FOOT TROUBLE				30. POLIO			
8. EYE INJURY, SURGERY OR DISEASE				31. RHEUMATIC FEVER			
9. HAVE YOU EVER WORN GLASSES OR CONTACT LENSES				32. HEART TROUBLE, INCLUDING CIRCULATORY			
10. HARD OF HEARING OR HEARING PROBLEMS				33. HIGH OR LOW BLOOD PRESSURE			
11. WORN A HEARING AID				34. VARICOSE VEINS			
12. HEADACHES				35. PERNICIOUS ANEMIA, LEUKEMIA OR OTHER BLOOD DISORDER OR AILMENT			
13. MENTAL ILLNESS OR NERVOUS BREAKDOWN				36. HEPATITIS, JAUNDICE OR OTHER LIVER AILMENT			
14. ADDICTION TO DRUGS OR ALCOHOL				37. DIABETES OR SUGAR IN URINE			
15. FAINTING OR DIZZY SPELLS				38. ULCERS OR OTHER STOMACH TROUBLE			
16. EPILEPSY OR FITS				39. COLITIS			
17. ANY DISORDER OF THE NERVOUS SYSTEM				40. GALL BLADDER TROUBLE			
18. TUBERCULOSIS OR OTHER LUNG TROUBLE				41. KIDNEY OR BLADDER TROUBLE			
19. SHORTNESS OF BREATH				42. PILES OR HEMORRHOIDS			
20. ASTHMA				43. RUPTURE OR HERNIA			
21. BRONCHITIS				44. MONONUCLEOSIS			
22. POISON OAK OR POISON IVY				45. CHEST PAIN OR DISCOMFORT			
23. SKIN TROUBLE							

46. HAVE YOUR HAD ANY OTHER ILLNESS, INJURY OR PHYSICAL CONDITION NOT NAMED ABOVE, OTHER THAN CHILDHOOD DISEASES OR MINOR ILLNESSES? IF "YES," PLEASE EXPLAIN:			
47. HAVE YOU EVER HAD OR BEEN ADVISED TO HAVE AN OPERATION? IF "YES," PLEASE GIVE THE NATURE AND DATE(S) OR OPERATION(S):			
48. HAVE YOU EVER BEEN A PATIENT (COMMITTED OR VOLUNTARY) IN A MENTAL HOSPITAL? IF "YES," GIVE REASON(S), DATE(S), AND PLACES(S):			

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Medical Examination Report

INSTRUCTIONS TO EXAMINING PHYSICIAN: Please review Health Questionnaire before examining the applicant. Do not return this report to applicant until lab results are received. Use section 13 for explanation of details, if necessary.

1. Height: (without shoes)	**Weight:** (without shoes & coat)	**Chest Girth:** (Expiration)	**Abdominal Girth:**
_____Feet _____Inches	_____ Pounds ❍ Normal ❍ Abnormal	_____ Inches	_____ Inches

2. Visual Acuity: (if applicant wears glasses, test and record both with and without glasses)

Pupils: ❍ Equal ❍ Unequal Glasses: ❍ Yes ❍ No

Eye Grounds: ❍ Normal ❍ Abnormal Contact Lenses: ❍ Yes ❍ No

Visual Grounds: ❍ Normal ❍ Abnormal

3. Hearing: (whispered conversation at 15 feet is considered normal)

Right: ❍ Normal ❍ Abnormal Hearing Aid Used: ❍ Yes ❍ No

Left: ❍ Normal ❍ Abnormal Ear Drums: ❍ Normal ❍ Abnormal

4. Head: (note any defect or disease)

Nose: ❍ Normal ❍ Abnormal Teeth: ❍ Good Repair ❍ Need further work

Mouth: ❍ Normal ❍ Abnormal

5. Lungs: ❍ Normal ❍ Abnormal

6. Cardiovascular System:

Type of Action	Blood Pressure	Pulse Rate
At Rest		
After Moderate Exercise		
Two Minutes after Exercise		

Heart Sounds: ❍ Normal ❍ Abnormal Gallops or Extra Sounds: ❍ Yes ❍ No

Rhythm: ❍ Normal ❍ Abnormal Murmurs: ❍ Yes ❍ No

Peripheral Pulse: ❍ Normal ❍ Abnormal Any Bruits: ❍ Yes ❍ No

7. Abdomen:

Masses: ❍ Yes ❍ No

Tenderness: ❍ Yes ❍ No

Organomegaly: ❍ Yes ❍ No

Hernia: ❍ Yes ❍ No

8. Rectal:

Fissure: ❍ Yes ❍ No

Fistula: ❍ Yes ❍ No

Hemorrhoids: ❍ Yes ❍ No

Prostatic Abnormalities: ❍ Yes ❍ No

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9. Genitourinary: (describe any abnormalities)				
10.	**MUSCULO-SKELETAL** (Test by bending, stooping, squatting; also by head, arm, leg, and finger motion.)			
A. Spine	Mobility	Symmetry	Posture	X-Ray Recommended: ❍Yes ❍No
B. Upper Extremities	Limited Function		Missing Parts	
C. Lower Extremities	Limited Function		Missing Parts	
Comment on any deformities or limitations of motion:				
11. Skin: (scars, variscosities, rashes, disease, other abnormalities – describe nature and severity)				
12.	**LABORATORY** (Report may be attached)			
A. Urinalysis :	Sp. Gravity	ALB.	Sugar	Microscopic
B. Serology (VDRL) ❍ Positive ❍ Non-reactive _____Blood Type				
C. Tuberculin ❍ Positive ❍ Negative				
D. Hematocrit: _____%				
E. For Female Applicants: Pregnancy: ❍ Positive ❍ Negative				
13. Comments/ Summary: (Describe any abnormalities in 1 – 12)				
Are there any conditions, physical, mental or emotional, which in your opinion, suggest further examination? ❍Yes ❍No			Do you have any reservation about this applicant's ability to physically or mentally perform the duties _____? ❍Yes ❍No	
As the examining physician I stipulate to having reviewed the applicant's health questionnaire.				
Physician's Signature:			Name & Address of Physician (type or print)	
Date:				